Inter-agency adult support and protection practice: a realistic evaluation with police, health and social care professionals

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Introduction

Collaborative inter-agency working is of paramount importance for public protection worldwide. This paper reports on a Scottish study that focussed on the coordinated and integrated practices amongst the police, health and social services' professionals who support and protect adult members of society at risk of harm. It investigated perceptions of gaps and concerns in interagency working using a realistic evaluation approach (Pawson and Tilley 1997).

Previous studies have called for integrated working but there is a paucity of research examining integrated practice (Parker et al 2017; Higgins, Hales and Chapman 2016; Mackay et al 2011; Petch 2008). Parker et al (2017) conducted a scoping review of the international literature and found thirteen models of interagency collaborative care for mental health related interactions between the police and mental health and emergency care services. They acknowledged the need for further research that focussed on the key elements of integrated care which include information sharing; joint decision making and coordinated intervention. This study focuses on such practises that cross organisational boundaries.

The Scottish Context

In Scotland, The Adults with Incapacity (Scotland) Act (2000); the Mental Health (Care and Treatment) (Scotland) Act 2003 and the

2007 Adult Support and Protection Act (ASP) introduced significant changes in the support offered to adults considered to be at risk of harm. In ASP legislation an adult is defined as 16 years and above and 'at risk' adults may include those with 'disability, mental disorder, illness or physical or mental infirmity and are more vulnerable to being harmed than adults who are not so affected'. The ASP Act provides measures to identify, support and protect those individuals who are at risk of harm, whether as a result of their own or someone else's conduct. It clarified the roles and responsibilities of those involved in ASP and by adopting codes of practice professionals complied with the legislation (Scottish Government 2014). To define 'at risk' the ASP Act introduced the '3 point test.' This identified (1) if people were unable to safeguard well-being, property etc.; (2) that they were at risk of harm and (3) that the effect of their disability meant that they are at a greater degree of vulnerability. There is recognition within the legislation that a multi-agency approach is required.

Multi-Agency and Cross boundary working

It is a challenging undertaking for any professional to practise effective collaborative working given the complex knowledge and skills needed to create effective channels of communication. There is an assumption that professionals working within health and social care integration alongside police colleagues know how to work collaboratively. Discerning the mechanisms to achieve joint-working remains difficult (Stevens 2013; Police Scotland 2016). However, there is evidence of effectiveness when adopting multi-agency practices. For example: in their consideration of violent crimes

in two policing areas in England Higgins, Hales and Chapman (2016) found partnership working to be effective and resulted in a reduction of crime.

A key challenge for adult support and protection is empowering 'at risk' adults and also respecting their liberties, balancing the need for professional interventions, when they are perceived as making choices which put them at risk of harm.

The ASP Act (Scottish Government 2007) provides clarity and balance between an individual's right to freedom of choice and the risk of harm. Working collaboratively in ASP requires formulating professional judgements; understanding definitions and thresholds and often working in environments without a "culture of co-operation" (DOH 2010). Such difficulties can restrict communication and information sharing, particularly with sensitive personal data owing to varying ethical practices. There are no specific UK figures available on information sharing for adult protection, however Cambridge et al (2010) investigating 6100 adult protection referrals in two local authorities in England, found a dramatic increase in police referrals from 20% in 1998 to 40% in 2005 whilst health referrals remained static at 21%. Reasons for these differences required further investigation but could potentially relate to adult support and protection policy and legislation changes during this time. Eighty four per cent of all referrals in the study led to investigation with significant joint working in 10% of referrals. The report on the effectiveness of adult protection arrangements across Scotland (Care Inspectorate Scotland 2014) failed to identify figures for information sharing.

This current study was therefore deemed important in addressing ASP practices in Scotland and enhancing the information required to promote exemplary joint working for safeguarding adults.

Aim of study

The aim of this study was to investigate the interagency practice of police and health and social care professionals in Scotland in relation to Adult Support and Protection.

The research questions were as follows

Phase 1: To identify: (i) existing gaps in the implementation of effective interagency practice by reviewing the "state of play" in interagency collaboration between the police and health and social care professionals; (ii) education and training needs in relation to key ASP issues, and (iii) information sharing.

Phase 2: To identify interprofessional and interagency training resources with key performance indicators to enable subsequent evaluation and monitoring of practice for all professionals involved in adult support and protection.

Study Design

A qualitative study, using an adapted 'realistic evaluation approach' (Pawson and Tilley 1997) was designed to evaluate interagency practices. A steering group of experts from across Scotland guided the project team. The steering group members are included in the acknowledgements. The study was funded by the Scottish Institute for Policing Research (SIPR) and included two phases: This paper focuses on the findings from *Phase 1* of this study.

Figure 1 provides an overview of the study design used to generate 'Context-Mechanism-Outcome' configurations (Pawson and Tilley

1997).The configurations identified: (i) for whom it worked; (ii) in what way, and (iii) why it worked or not.

For example

(i) collaborative practices were working for health, social care and police professionals in some urban locations and most rural locations

(ii) the ways in which it workedrelated to good communication practices across organisational boundaries

(iii) collaborative practice was achieved because when they worked in small cohesive teams and had built up trust and respect for each other over some time.

Figure 1 Study Design using a 'Realistic Evaluation' Approach

Representative numbers of professionals from each of the disciplines responsible for ASP were invited to participate in focus groups, via the different ASP committees and the Health Boards and Police Command Areas across Scotland. Figure 2 highlights the police divisions within the three command areas (14 divisions) from which the sample groups were drawn. The study focussed on professionals and their descriptions and experiences of the services. We acknowledge the distinctions in terminology between 'social services' and 'social care'. Our study included both social workers and other professionals working in social care. The terms are used synonymously in this paper.

Figure 2 Police Divisions, Local Authorities and Health Boards within three command areas for Police Scotland

NB: At the time of the study this was the structure for Police, Health and Social Care in Scotland. A and B Divisions have since merged to become 'North East Division'.

The corresponding areas for Local Authorities and Health Boards were matched according to the associated police division (see Figure 1). There was no direct correlation and a potential problem in communication and information sharing when boundaries do not co-align was identified.

Focus groups with single disciplines (i.e. police only, health only or social care only) and mixed were conducted. Ethical approval was granted by the Ethics Committee at Robert Gordon University.

Focus Groups

The focus groups were audio recorded and facilitated by different team members. The schedule introduced the realistic outcome questions i.e. (i) for whom it worked; (ii) in what way, and (iii) why it worked or not. All focus groups included a simulated case study developed from anonymised 'real case' histories. The purpose of this was to ensure that the discussions could be focused and deeper insights into the participants' thinking and decision making practices were consistently evaluated. From a research perspective this strengthened reliability from the theoretical points made during focus group discussions and validated their professional practice.

Table 1 Total Participant Numbers by Area and Profession

Findings

Thirteen focus groups, involving 101 participants, were recorded and transcribed verbatim. Framework analysis (Ritchie et al 2013) was used to identify categories, themes and sub-themes. Eight key themes, as highlighted in Table 2, were identified.

Table 2 Key Themes from Focus Groups

The key themes from Table 2 are discussed individually.

1. ***Information sharing*** included discussions on two main topics. Firstly, the development of an 'at risk persons' database for all professions was identified as an important step for improved practice. Secondly, participants identified challenges with information sharing across different professions that was exacerbated by the need to protect confidentiality. Police and social work reported frustration at healthcare professionals' reluctance to share information.
2. ***'Relationships'*** highlighted that 'team working' and 'information sharing' are greatly improved when organisations are co-located and/or informal relationships are established resulting in greater collaborative working and the development of trust for information sharing.
3. ***People and processes*** identified both positive and negative influences for working practices. If protocols and processes were 'unfit for purpose' then this was a demotivating factor for collaborative working. In contrast, where processes were working well and professionals felt included, the system motivated collaborative working. The 3 point test for identifying if an adult is vulnerable in Scotland (Scottish Government 2007) was criticised by more than half of the participants. Perceived police over-reporting of persons who may not 'fit' the test resulted in some social workers reporting less scrutiny of police reports. Conversely, when more than one agency was involved in a case there was a perceived reliance on

the police to submit the report, when all agencies should have submitted their own concerns.

4. ***'Lessons from child protection'*** related to the established and effective practices that already exist for child protection cases. Participants noted that there were no confidentiality and information sharing issues in child protection cases. This was perceived as positive and recommended as an aspiration for ASP.
5. ***'Environment'*** related to the lack of places of safety for at risk adults to recover from an acute episode. The closure of safe environments such as hospital wards has led to some individuals being inappropriately 'locked up' in police cells.
6. ***Implementation of The Adult Support and Protection Act*** **(2007)** stipulates local authority social work departments' responsibilities as the coordinators for interagency working practices. However, participants felt that this Act had not fully met the needs of the people it was intended to support and protect. This has led to some challenging decision-making by professionals.
7. ***Regional variations*** were obvious throughout the focus groups. Remote and rural areas had developed more cohesive team arrangements and practised cross boundary working. Urban locations tended to report fragmented team working and a lack of understanding which often resulted in a lack of information sharing.

8. ***The rights of the individual*** were perceived differently amongst participants. Debates centered on the rights of the individual to adopt a 'risky' lifestyle choice and the need for professionals to 'protect and support'.

Table 3 Topics raised during Case Study discussion

The case study discussion at the end of each focus group provided valuable insights into participants' thinking and decision making processes. The narratives were analysed verbatim using Framework analysis (Ritchie et al 2013). Table 3 highlights the disparity noted amongst professionals when discussing the case study. The references made to the stages of action by different professionals for the case presented, demonstrated strengths and weaknesses in interagency working. In some focus groups there was greater agreement as to what the decisions and actions of each profession would be and how they would also work collaboratively sharing information and often conducting joint investigations. In some focus groups there was greater disparity in the expectation of other professionals and inconsistencies in decision making. ocus group data led to the development of context-mechanism-outcome analysis.

Context-Mechanism-Outcome (CMO)

Table 4 highlights the CMO analysis of the multi-factorial processes involved to illuminate the findings. This analysis allows an exploration of the multiplicity of factors that impact on adult support and protection practices. The Pawson and Tilley model

(Pawson and Tilley 1997) has been adapted as follows: The ***context*** were facts related to the status quo and on most occasions reflected what was not working. The ***mechanisms*** were enablers (i.e. the policies, processes and innovative approaches) that facilitate the safeguarding of vulnerable adults. The ***outcome*** were the stipulated sequels that arose if the context was sustained and the mechanism enabled improvement. By linking this to the three questions (i.e. 'for whom it works' and 'in what way and why it works'), a strategy for improved future practice was provided.

Table 4 CMO Analysis

CMO 1 Geographical Location Further analysis identified gaps in interagency working relating to geographical location. Many urban teams reported larger caseloads and fewer resources to deal with issues other than 'protection'. Rural areas and specialised teams within urban areas worked more cohesively adopting formal and informal communication strategies The lack of places of safety for at risk clients was perceived as a gap in resource provision that had not been there previously.

CMO 2 Environment The context here is environment and related to a place of safety and the mechanisms related to the decision making processes leading to positive or negative outcomes for vulnerable adults.

The difficulties with the definitions of mental 'capacity' were noted by all professionals. The police perceived that they are not the recognised profession to make a 'diagnosis' in relation to capacity or to assess risk.

However they reported being 'left' to make these judgements when medical colleagues were unable, or unavailable, to assess capacity and social work colleagues were unable to locate legislation upon which they could intervene. The Police have to deal with these situations without adequate support for diagnosis and safe location from health services.

CMO 3 Capacity

Here the context relates to clients with capacity issues and the mechanisms rely on appropriate assessment leading to positive or negative outcomes. The initial referral and shared decision making processes were hindered in some areas due to unavailability or lack of involvement of some professionals, and more than half of the health staff were identified as falling into this category. One aspect that widened this gap was the lack of compatibility and interoperability for transferring information.

CMO 4 Referrals The mechanisms denote the professional differences in terms of the number and value of referrals and the outcomes relate to safeguarding. Police professionals described consistent referral practices with most vulnerable adults being referred to social services. Social care workers described practices that prioritised police referrals into those that were high priority only, as they did not feel they had the resource capacity to manage them all. Health professionals described very low referrals to either police or social services. The outcomes therefore demonstrated that safeguarding of adults could potentially be compromised by these difference in professional practices with potential risks to adults in need of support and protection.

Discussion

The findings identified barriers and also ways of overcoming the barriers. The following aspects are highlighted for discussion.

Place of Safety

There were many references from participants acknowledging the importance of a place of safety for vulnerable people and these were seen as hospital based or social service provision and as a last resort police cells. Findings indicated that police professionals often accompanied adults into A&E services and contacted mental health organisations. They reported wasting time '*babysitting*' clients in A&E for up to 4-5 hours whilst waiting for medical colleagues to conduct assessments, but also spoke of '*not being able to walk away'* due to the vulnerability of the client. The closure of statutory provisions of places of safety and the policy of 'deinstitutionalisation' has led to increased police contact with those at risk of harm and particularly those with acute mental illness. Police officers argued that their training in dealing with these vulnerable clients was minimal, concurring with other researchers (Herrington and Pope, 2013 and Laing et al, 2009). They spoke of working around systems and processes, crossing boundaries and coined the term, '*boundary spanners'* to explain how they overcame barriers to protect and safeguard. Some police participants identified health colleagues with whom they had forged good relationships and who were able to provide timely advice when official channels of communication had failed. However, barriers to communication were also noted when there

was a perceived 'no answer' from social services for out-of-hours calls.

Assessing capacity

Whilst the assessment of capacity has been made easier by the introduction of the criterion based tests (Mental Capacity Act 2005; Adult support and protection (Scotland) Act 2007) the implementation of these tests requires a degree of mental health awareness from skilled health professionals. If they were unavailable police officers perceived that they were compelled to make decisions that did not always lead to the best outcomes for the adult at risk.

Partnership working for 'joint assessment' was apparent in some areas with social work and police working together. Improvements within the 2016 vision for Police Scotland (Police Scotland 2016) acknowledged that all professions need training whilst also recognising that police officers cannot and should not take on the roles of social workers and community psychiatric nurses for assessing capacity.

Interprofessional differences

The notion of recognising professional differences within partnership and collaborative working is an important skill. It relies on cohesive team working, mutual trust and respect for each professions' knowledge and expertise (Hammick et al 2009). This study found this to be true with recognition of role- differentiation to provide the best outcomes for vulnerable adults and their families. Hall (2005) described this as different professionals

finding similarities when seeing something together and yet identifying very different things. The case study discussion during the focus groups confirmed this.

Professional differences affected judgements and decision making. Police professionals were found to be most 'risk averse'; social workers the least and health professionals somewhere in between. There was an awareness from social work professionals to 'live and let live', recognising the rights of individuals to live 'risky' lives. Whereas police professionals preferred to make a decision on life choices implying 'better' outcomes for the adult and other members of the public. Participants spoke of challenging debates at case conferences on this issue.

Information sharing

Information sharing is an area affected by professional allegiances and was most apparent from the health professions. Data revealed that General Practitioners (GPs) were especially reluctant to share information to police and social work professionals based on the need to adhere to data protection and protect the special 'privileges' of the doctor-patient relationship. Social workers were perceived as acting as 'boundary spanners' to access information. GPs were not perceived as having any concerns about the doctor-patient relationship in situations where discussions pertained to child protection issues. Participants advocated that professions should learn the lessons from child protection. However, these two aspects of protection are not comparable and information sharing within the context of child protection occurs more readily because

the child is deemed unable to give consent. The challenge in ASP is one of capacity where the adult is deemed capable so can refuse consent to information sharing.

Informal information sharing was deemed to be more reliable than formal information sharing, concurring with previous work (Cotter, 2015; Cambridge et al 2010; Petch 2008). ASP data on information sharing and Care Inspectorate Scotland's (2014) report also concur with this study's findings (2013-2014). Police officers who had reported and documented concerns, were disappointed when these were subsequently deemed low priority for social services. The call for comprehensive audit arrangements that provide leadership and direction for ASP continues to be identified in the literature (Care Inspectorate Scotland 2014) despite codes of practice demanding audit information since 2009.

Joint Working- 'Rural and Urban Split'

From the study it appears that most rural teams worked cohesively and were able to cross boundaries easier than some urban teams. There were exceptions to this, however, when urban teams were more specialised, focusing on specific areas (e.g. domestic abuse) close working relationships had developed.

When teams were more opportunistic in composition because of location or size, it was difficult to develop good relationships and the data revealed concerns regarding achievement of quality standards for safeguarding adults. Cambridge et al (2010) described 'territorial variations' between two English local authorities. They concluded that this portrayed the national picture

for England and called for the development of key performance indicators (KPIs) in ASP. From the findings of this study, parallels can be attributed to the Scottish picture and *Phase 2* of this study developed KPIs for ASP.

Strengths and Limitations

This unique Scottish study successfully identified the interagency practices of health, social services and police. By means of a modified realistic evaluation approach, it provides an in-depth understanding of the challenges that professionals face on a day to day basis when safeguarding adults and informed strategic recommendations to overcome the barriers to good practices in organisational working. The methods used to determine context-mechanism- outcome could benefit other researchers to develop studies exploring the complexities of multi-causal effects of cross-boundary working.

The use of the same case study in each focus group helped to neutralise bias. However, the voluntary nature of participation could have resulted in biased perceptions. The limited numbers of health professionals may have resulted in less representation of health sector views.

It is important to acknowledge that this research was conducted during the introduction of Police Scotland in April 2013 when eight police forces were merged. Practices may have changed since the data collection period. In particular there has been the re-structuring of public protection units to include 'Risk and Concern Management Hubs' in each Division. These hubs are responsible for collating and assessing 'concern reports' on adults at risk; child protection; hate crime and domestic abuse incidents. The hubs focus on improving Police Scotland's approach to wellbeing concerns with

identification of opportunities for early intervention and prevention through strong partnership working. The strategy for the next ten years provides a clear vision for change but also identifies vulnerabilities in policing (Police Scotland 2016).

Conclusion

This qualitative study has investigated the interagency ASP practices of police, health and social care professionals in Scotland. It provided information on ASP that concurred with the few studies and reports available (Cambridge et al 2010, Care Inspectorate Scotland 2014) but the need for further research and updating of current reports was recognised. It was unique in identifying gaps in the working practices of ASP professionals that can be attributed to their own understanding of interagency working and the expectations of partner agencies. Participants referred more to the generic term 'Public protection' widening the remit of the study.

Processes were practiced differently in different areas and professional differences in decision making also resulted. Debates centred on the rights of the individual to adopt a 'risky' lifestyle choice and the need for professionals to 'protect and support'.

This was of particular significance for reporting and referral where all agencies involved in a case are expected to submit a report providing a clear understanding of the interagency perspectives. The development of an at risk persons' database that all professions could access was identified as an important step for improved practice and is work in progress.

Recommendations from this study include the need to strengthen information sharing and improve interdisciplinary education and training.

This would potentially result in improved collaborative decision making, closing some of the gaps in practice. Further longitudinal research studies and incidence related audit trails are recommended to assist in the evaluation of practitioners' skills in the changing world of public protection. Whilst the focus of this study has been on adult support and protection the conclusions and recommendations are transferable to public protection issues in many other contexts.

Acknowledgements

The following people are acknowledged for their valuable contribution to this research project: All the Adult Support and Protection Professionals in Scotland who participated in the focus groups

Project Team Member: Mrs. Inga Heyman Lecturer, Edinburgh Napier University, Edinburgh

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John Myles, Independent Chair Adult Protection Committee, Fife

Kenny O'Brien, Adult Protection Unit Co-ordinator, Aberdeen City Council

Dr. Rebecca Riddell, Locum General Practitioner, Lead for Clinical Communication Division of Medical and Dental Education, University of Aberdeen

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References

CAMBRIDGE, P., BEADLE-BROWN, J., MILNE, A., MANSELL, J. and WHELTON, B. 2010. Adult protection: the processes and outcomes of adult protection referrals in two English local authorities. Journal of social work 11(3) pp 247-267

CARE INSPECTORATE SCOTLAND 2014. A report on the effectiveness of adult protection arrangements across Scotland. [online] Available from: http://www.careinspectorate.com/images/documents/1059/Adult%20protection%20arrangements%20across%20Scotland.pdf [Accessed 6th June 2018]

COTTER, R.S. 2015. Police intelligence: connecting –the –dots in a network society. *Policing and Society,* 27(2) pp. 173-187. [online] Available from: http://dx.doi.org/10.1080/10439463.2015.1040794 [Accessed 6th June 2018]

DEPARTMENT OF HEALTH 2010. Government Response to the Consultation on Safeguarding Adults: The Review of the No Secrets Guidance, Department of Health, London. [online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197743/Response157.pdf [Accessed 6th June 2018]

HALL, P. 2005. Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*. 19(Suppl.), 188–196.

HAMMICK, M., FREETH, D., COPPERMAN, J. and GOODSMAN, D. 2009. *Being interprofessional.* Cambridge: Polity Press

HERRINGTON, V and POPE, R. 2013. The impact of police training in mental health: an example from Australia. *Policing and Society,* 24 (5) pp. 501-522. [online] Available from: http://dx.doi.org/10.1080/10439463.2013.784287 [Accessed 6th June 2018]

HIGGINS, A., HALES, G. and CHAPMAN, J. 2016. Police effectiveness in a changing world. Multiagency case management: evidence and orthodoxy. *The Police Foundation.* Paper 3 [online] Available from: http://www.police-foundation.org.uk/project/police-effectiveness-in-a-changing-world/ [Accessed 18th August 2018]

LAING, R., HALSEY, R., DONOHUE, D., NEWMAN, C. and CASHIN, A. 2009. Application of a model for the development of a mental health service delivery collaboration between police and the health service. *Issues in Mental Health Nursing,* 30(5), pp337-341. [online] Available from: http://dx.doi.org/10.1080/01612840902754644 [Accessed 6th June 2018]

McKAY M., McLAUGHLAN, C.,ROSSI, S., McNICHOLL, J., NOTMAN, M., and FRASER, D. 2011.*Exploring how practitioners support and protect adults at risk of harm in the light of the Adult Support and Protection (Scotland) Act 2007*. Research Report. [online] Available from: http://dspace.stir.ac.uk/bitstream/1893/3524/1/ASP%20research%20report%20finalx.pdf [Accessed 6th June 2018]

PARKER, A., SCANTELBURY, A., BOOTH, A., MACBRYDE, J.C., SCOTT, W.J., WRIGHT, K. and MCDAID, C. 2017. Interagency collaboration models for people with mental ill health in contact with the police: a systematic scoping review. *British Medical Journal Open.* [0nline] Available from: doi:10.1136/bmjopen-2017-019312 [Accessed 18th August 2018]

PAWSON, R. and TILLEY, N. 1997. *Realistic Evaluation*. Sage, London.

PETCH, A. 2008. Safety Matters: the role of partnership working in safeguarding adults. *Journal of Integrated Care* 16 (6) pp 39-40 [online] Available from: https://www.emeraldinsight.com/doi/pdfplus/10.1108/14769018200800045 Accessed 6th June 2018

POLICE SCOTLAND 2016. 2026 Serving a changing Scotland: Our 10 year strategy for policing in Scotland. [online] Available from: http://www.scotland.police.uk/assets/pdf/138327/386688/policing-2026-strategy.pdf [Accessed 6th June 2018]

RITCHIE, J. LEWIS, J., NICHOLLS, C. and ORMSTON, R. 2013. Qualitative Research Practice: A guide for social science students and researchers 2nd ed. London: Sage

SCOTTISH GOVERNMENT 2014. Adult Support and Protection (Scotland) Act 2007: Code of Practice [online] Available from: http://www.gov.scot/Publications/2014/05/6492 [Accessed 6th June 2018]

SCOTTISH GOVERNMENT, 2007. Adult Support and Protection (Scotland) Act 2007.
[online] Available from:
http://www.legislation.gov.uk/asp/2007/10/contents [Accessed 6th June 2018]

SCOTTISH GOVERNMENT, 2003. Mental Health (Care and Treatment) (Scotland) Act [online] Available from:
http://www.legislation.gov.uk/asp/2003/13/contents [Accessed 6th June 2018]

STEVENS, E. 2013. Safeguarding vulnerable adults: exploring the challenges to best practice across multi-agency settings. Journal of Adult Protection. 15(2) pp.85-95 [online] Available from:
https://www.emeraldinsight.com/doi/pdfplus/10.1108/14668201311313596 [Accessed 6th June 2018]

UK GOVERNMENT 2005. Mental Capacity Act [online] Available from:
http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf [Accessed 6th June 2018]

Author biographies:

Dr. Sundari Joseph is Senior Lecturer, Aberdeen's Interprofessional Education (IPE) advisor and Vice Chair of Centre for the Advancement of Interprofessional Education (CAIPE). Her career has focussed on nursing, health visiting and education. Sundari has developed new ways of delivering education for collaborative working and is recognised by the Higher Education Academy (UK) with the award of Principal Fellow. IPE Aberdeen was seen to be exemplary and included in a UK review. She has presented at many international IPE conferences and has presented this study at the Scottish Parliament.

Professor Susan Klein is the former Director of the Aberdeen Centre for Trauma Research (ACTR) at Robert Gordon University. In February 2017, Susan joined Anglia Ruskin University as a part-time Professor of Health and Social Care with a specific remit to act as a strategic research advisor to the Veterans and Families Institute. She has a particular research interest in identifying resilience-related factors pertaining to psychosocial adjustment and growth post-trauma at individual, community and organisational levels.

Dr Penny Woolnough is a Senior Lecturer in Forensic Psychology at Abertay University in Dundee, Scotland and Associate Director (Evidence and Investigation) of the Scottish Institute for Policing Research. Prior to this she worked directly with the police service as Senior Research Officer at Grampian Police / Police Scotland for 14 years. Over the past 17 years she has conducted extensive research on missing persons and pioneered the development of geo-spatial and behavioural profiling guidance which is used routinely by UK and international police agencies to inform: risk assessment, investigative decision making and search strategies.

Superintendent Samantha McCluskey has worked in a number of areas including Female and Child Unit, Family since joining Strathclyde Police Force in 1993 Liaison, Covert Human Intelligence, Domestic Abuse and Professional Standards. She is a trained Senior Investigating Officer, a qualified and experienced investigative interviewer and investigative interview trainer. She is also a qualified police instructor having completed courses in presentation skills, training delivery and course design and evaluation. She has delivered numerous specialist detective training courses as well as the National Hostage and Crisis Negotiator Course (Scotland) and Hostage and Crisis Negotiation Course delivered to an international audience. In 2010 she was awarded a Scottish Government Highly Commended Award for work developing national counter fraud and economic crime investigation and in 2015 she was nominated for a British Association for Women in Policing Award under the category of Excellence in

Performance. She is currently Superintendent in Police Scotland's Professional Standards Department.

Professor Lesley Diack is professor of Transdisciplinary and Technology Enhanced Learning. Managing a four year WELLCOME TRUST funded project was part of her lecturer/researcher role at the University of Aberdeen. In the area of transdisciplinary and technology enhanced learning, at RGU her funded projects total over £1.3m. Funders include: Scottish Government, the Digital Health and Social care Institute (DHI), Innovate (UK), Janssen-Cilag, with collaborators in Europe, Japan, Australia the USA and Qatar.

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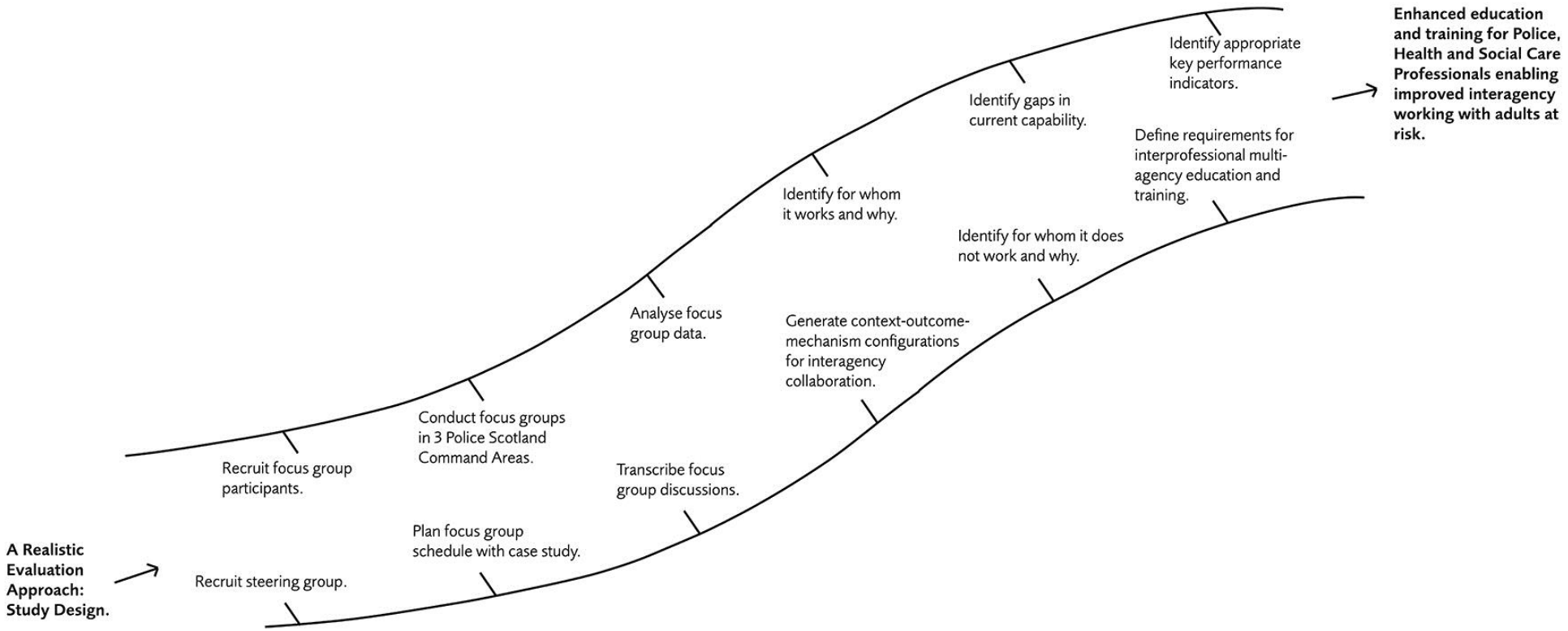
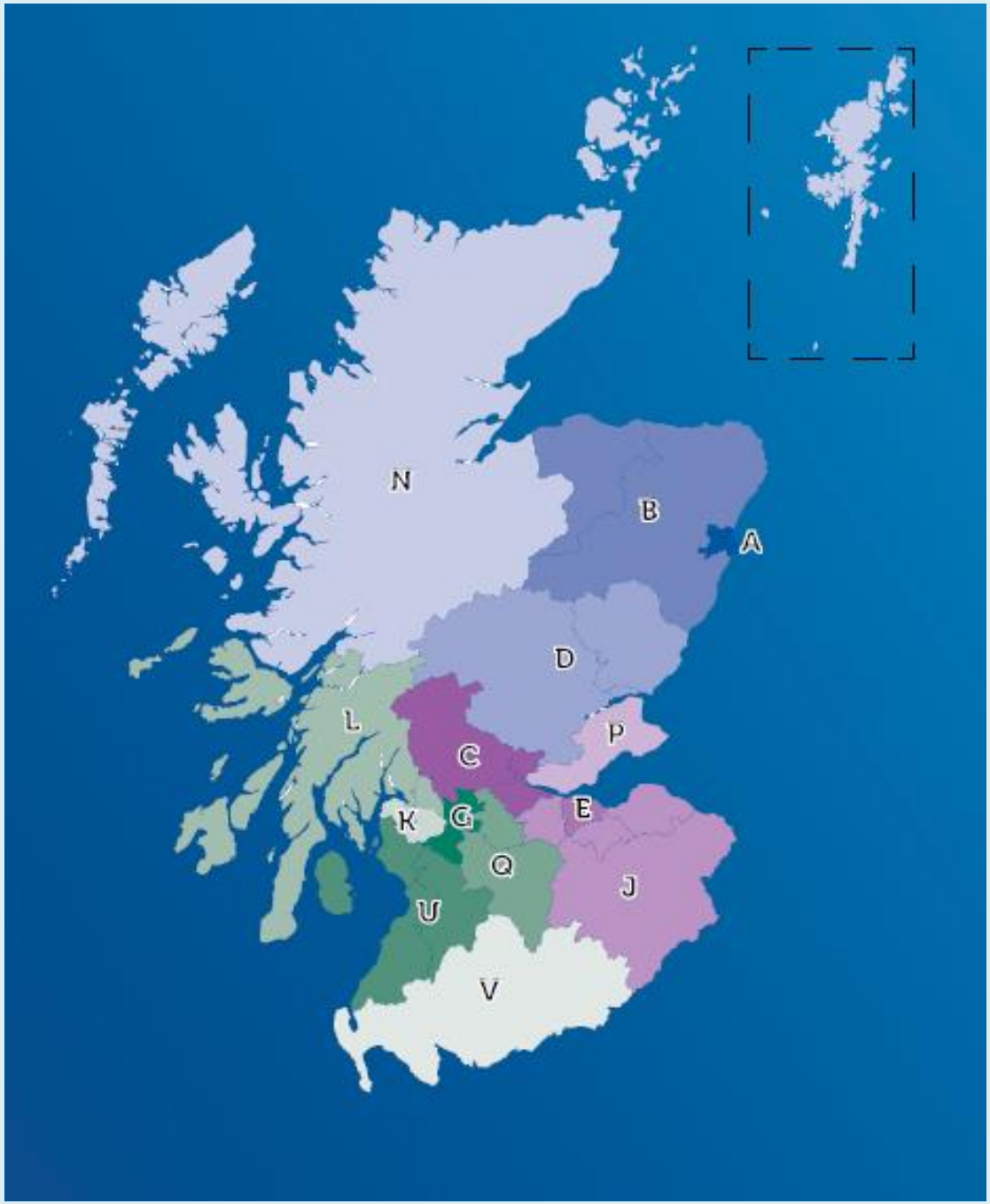
Figure 1


A Realistic Evaluation Approach: Study Design.
Recruit steering group.
Plan focus group schedule with case study.
Recruit focus group participants.
Conduct focus groups in 3 Police Scotland Command Areas.
Transcribe focus group discussions.
Analyse focus group data.
Generate context-outcome-mechanism configurations for interagency collaboration.
Identify for whom it works and why.
Identify for whom it does not work and why.
Define requirements for interprofessional multi-agency education and training.
Identify gaps in current capability.
Identify appropriate key performance indicators.
Enhanced education and training for Police, Health and Social Care Professionals enabling improved interagency working with adults at risk.

Focus Groups Accessing Police, Health, Social Care Staff involved in Adult Support and Protection, Scotland



Focus Groups	Division	Local Authority	Health Boards
	NORTH Command		
Police Only Health Only Social Care only Mixed- Police, health and Social Care	A Aberdeen	Aberdeen	NHS Grampian
	B Aberdeenshire & Moray	Aberdeenshire & Moray	NHS Grampian
	D Tayside	Angus, Dundee City, Perth & Kinross	NHS Tayside
	N Highlands and Islands	Eilean Siar, Highland, Orkney, Shetland	NHS Orkney; NHS Shetland; NHS Western Isles; NHS Highland
	EAST Command		
Police Only Health and Social Care Mixed- Police, health and Social Care	C Forth Valley	Clackmannanshire, Falkirk, Stirling	NHS Forth Valley
	E Edinburgh	Edinburgh	NHS Lothian
	J The Lothians and Scottish Borders	East Lothian, Midlothian, West Lothian, Scottish Borders	NHS Lothian; NHS Borders
	P Fife	Fife	NHS Fife
	WEST Command		
Police Only Health and Social Care Mixed- Police, health and Social Care	G Greater Glasgow	Glasgow, East Dunbartonshire, East Renfrewshire	NHS Greater Glasgow and Clyde
	U Ayrshire	East Ayrshire, North Ayrshire, South Ayrshire	NHS Ayrshire and Arran
	Q Lanarkshire	North Lanarkshire, South Lanarkshire	NHS Lanarkshire
	L Argyll & West Dunbarton	Argyll & Bute, West Dunbartonshire	NHS Greater Glasgow and Clyde
	K Renfrewshire & Inverclyde	Renfrewshire, Inverclyde	NHS Greater Glasgow and Clyde
	V Dumfries & Galloway	Dumfries & Galloway	NHS Dumfries and Galloway

Figure 2 Police Divisions within three command areas for Police Scotland during the time of the study

Table 1 Total Participant Numbers by Area and Profession

Breakdown by Area	Total Number of Participants	Police	Health	Social Care
North	47	18	13	16
East	28	19	1	10
West	26	15	4	5
Totals	**101**	**52**	**18**	**31**

Table 2 Key Themes from Focus Groups

Theme	Quotation
1. Information Sharing	Respondent PO3FG1 (Police). '… there is a well-established format within the police to pass on information to our partner agencies …but it doesn't always flow back to us in a way that we would want it ...'
2. Relationships	PO1FG1 (Police) 'when we had a social care worker dedicated in our office … it worked really well, we were finding out all the information we had on the family.'
3. People and Processes	SW4FG2 (Social Work) 'We actually had one (case) recently and it was someone that didn't meet the 3 point test, but round the table the consultant Psychiatrists and people are saying 'he's a likely candidate to kill himself' and the Police are going 'well do something about it' what? Do you know and it's that bit they don't (do) because they're so risk averse …'
4. Lessons from Child Protection	SC1FG2 (Social Care) 'I think child protection's probably gone through that process, it's well established now what everyone's responsibilities are (known) whereas I think in adult protection you can almost see people dragging their heels at times, you know very reluctant to become a part of the process'.
5. Environment	SW2FG3 (Social Work) 'To be fair to health we

	shouldn't be taking hospital beds with people that are under the influence either and I mean I don't think it should be a cell either'.
6. Implementation of the Adult Support and protection Act	SC4FG3 (Social Care) 'You had a child at risk, you wrote that report and you got your order and that child was removed. To remove adults, despite (the Act), it's like what you were saying there about this person's very chaotic (lifestyle) they are in some people's eyes choosing to be this way you know, if they have capacity.'
7. Regional Variations	SC2FG4 (Social Care) 'I think working … with the police is really positive and we've got quite a good relationship with the referral unit works … '.
8. The rights of an individual	HC4FG7 (Health) 'There is the consideration around is this a 'vulnerable adult' or is this an 'adult at risk' and do we also need to be thinking about then referring them on to social work for instance or you know you were asking about what happens if you can't get social work in the middle of the night, very often we would use our police colleagues in a crisis situation where we felt there was an immediate risk to the person'.

Topic	Social Work	Police	Health
Workload	Workload; lack of resources; paperwork overload; Co-location facilitates immediate communication.	Not being able to walk away; Left to pick up the pieces.	A&E too busy to do referral; Expectation that police will refer; Few referrals from community; Liaison psychiatry overload; IT systems not compatible between agencies.
Case study assessment	Consent issues; Friends and neighbours often make the initial referrals.	Sexual offences; issues of alcoholism and mental health; Issues of engagement.	Challenges around co-morbidity of alcohol and mental health.
The Act and Assessment of capacity	Skilled in identifying how people 'Fit the Act'; Agreed ambiguity of the Act but also agreed ASP good piece of legislation; Capacity in case study; Problems associated with use of banning orders.	Challenges of the 3 point test; Understanding that Police are not able to make medical assessment.	Capacity fluctuating; Questioned if there is a need for reporting if person is a frequent attendee i.e. suicide attempts.
Roles and responsibilities	Key role for the hospitals especially in terms of mental health assessment; Issues around place of safety.	Responsibility to investigate criminality.	Lack of trust in assessment between partners; Not understanding that others are depending on health assessment.
Decisions	Emphasis on adult support with the case study not adult protection.	Interprofessional case conference but often it can be a uniprofessional decision.	Acknowledged the difficulties of getting someone admitted to hospital, especially psychiatric units.
Education and Training	Recommended joint investigation training.	Officers may not know the criteria; Agreed police should be trained	ASP training is uni-professional; NES project used in training.

		in ASP with other professionals.	

Table 3 Topics raised during Case Study discussion

Table 4 CMO Analysis

CMO 1 Geographical Location		
Context	**Mechanism**	**Outcome**
Rural location	Informal communication strategies and cross boundary working	Positive for joint working
Urban	Formal Communication strategies, less cohesive teams	Not satisfactory for joint working
Urban-specialised	Formal and Informal communication strategies, cohesive teams	Positive for joint working
CMO 2 Environment		
Context	**Mechanism**	**Outcome**
Hospital location	Decision making by A&E health professionals; mental health professionals	Not always satisfactory for vulnerable adults
Police Cell/ custody suite	Decision making by police professionals, after trying healthcare referral	Not satisfactory for vulnerable adults
CMO 3 Capacity		
Context	**Mechanism**	**Outcome**
Diminished capacity	Police assessment	Not always satisfactory for vulnerable adults
Diminished capacity	Health assessment	Positive outcomes for vulnerable adults if referred to appropriate specialists
Diminished capacity- recognising fluctuating capacity	Joint investigation and assessment with police, social work and healthcare professionals	Positive outcomes for safeguarding vulnerable adults
CMO 4 Referrals		
Context	**Mechanism**	**Outcome**
Referrals from health professionals	Not seen as a priority for healthcare	Minimal referrals- safeguarding adults compromised
Referrals from Police	High priority creates overload for social workers	Large numbers of referrals not always actioned- Risks for safeguarding adults
Referrals from social work	High priority for high risk cases- respect for the rights of individuals to undertake risky lifestyle choices	Less numbers of referrals- Risks for safeguarding adults